

# Oregon Dental Anesthesia

## FINANCIAL POLICY

### WELCOME

Thank you for choosing Oregon Dental Anesthesia as your anesthesia care provider. We are committed to providing you with our best possible care. Your clear understanding of and agreement to our practice financial policy is important to our relationship. The following is a statement of our Financial Policy. We require you to read and sign this document prior to any treatment.

### REGARDING DURATION OF ANESTHESIA

Fees will vary depending on the duration of the dental treatment. Your dentist will provide an estimate of the time needed for the procedure(s). While we work with your dentist to make every effort to present accurate fee estimates before each procedure, unforeseen situations occasionally arise during the course of treatment that necessitate a change in the treatment plan or in the fee for a particular procedure and the accompanying anesthesia.

**Our fee is \$200 for every 15 minutes of anesthesia provided.** We do not charge for recovery time.

**The estimated fee for anesthesia is due no less than 2 days prior to the scheduled appointment via credit or debit card.**

### FOR PATIENTS WITH INSURANCE

We will always supply a superbill following the appointment. This superbill (also known as a claim form) will have the appropriate dental insurance anesthesia codes and the doctor's portion filled out. This superbill can be sent directly to the insurance company to obtain maximum allowable reimbursement under your policy. Oregon Dental Anesthesia makes no guarantee regarding reimbursement from your insurance. We are not responsible for billing your insurance for our services, nor are we responsible for any payment/non-payment by your insurance.

It is important that reimbursement for the anesthesia fee by dental or medical insurance programs NOT be assumed. Many policies do not pay for anesthesia services for dentistry.

### DIVORCE DECREES

Oregon Dental Anesthesia is not party to your divorce decree. The responsibility for minors rests with the accompanying adult. The responsibility for payment for adults rests with the adult obtaining treatment and anesthesia.

### ACKNOWLEDGEMENT AND AGREEMENT

By signing below, you the patient (or guarantor, if the patient is under 18) agree to the above terms and have had opportunity to ask questions and have had those questions answered to your satisfaction.

I certify that I have read this financial policy. I understand and agree that I must pay for services at the time they are rendered. I understand that if I wish to bill insurance that is my responsibility. I certify that I fully understand this policy and agree to its contents.

Signature of patient (or responsible party) \_\_\_\_\_ Date \_\_\_\_\_